

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2017
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 283 W BROADWAY BLVD JEFFERSON CITY, TN 37760		
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F 000	INITIAL COMMENTS	F 000	This Plan of Correction is the Center's credible allegation of compliance.		
F 205 SS=D	<p>During the Recertification survey and complaint investigation #40415 and #40172 conducted 1/29/17 through 1/31/17 at Jefferson City Health and Rehab Center, no deficiencies were cited related to complaint #40415 under 42 CFR 483, Requirements for Long Term Care.</p> <p>483.15(d)(1)(i)-(iv)(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFER</p> <p>(d) Notice of bed-hold policy and return-</p> <p>(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (c)(5) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (c)(3) of this section.</p> <p>(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative</p>	F 205	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it.</i></p> <p>F205 Resident 86 returned to the facility 12/24/16. Resident 103 no longer resides in the facility.</p> <p>Audit of each nurse's station was completed to validate bed hold policy forms were available.</p> <p>Re-education regarding facility bed hold policy and providing copies to resident/responsible party who go to the hospital or on therapeutic leave began on 2/1/17. This was completed by the staff development coordinator by 2/09/17 for all nurses. PRN staff and staff on leave will receive education prior to working.</p> <p>Audits will be completed by the assistant director of nursing to validate that copies of bed hold notice upon transfer are provided for hospitalizations/therapeutic leaves.</p>	2/9/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 205	<p>Continued From page 1</p> <p>written notice which specifies the duration of the bed-hold policy described in paragraph (e)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of the facility's Admission Packet, medical record review, and interview, the facility failed to issue a written bed-hold policy to the resident and responsible party for 2 (#86 and #103) of 3 residents reviewed for admission, transfer, and discharge rights of 32 residents reviewed.</p> <p>The findings included:</p> <p>Review of the facility's admission packet revealed "...Notice of Bed-Hold Policy-If you are transferred out of the center to the hospital or choose an overnight therapeutic leave, we will provide written information about our 'bed hold' policy to you. What this means is that under certain circumstances, including receipt of written or verbal request for a bed hold, the center will 'hold' a bed for the resident to be re-admitted..."</p> <p>Medical record review revealed Resident #86 was admitted to the facility on 8/28/15 and readmitted on 12/24/16 with diagnoses including Malignant Neoplasm of the Thyroid Gland, Acute Respiratory Failure, and Anxiety Disorder.</p> <p>Medical record review revealed Resident #86 was transferred to the hospital on 12/21/16 due to nausea, vomiting, and difficulty breathing.</p> <p>Medical record review revealed no documentation a written bed-hold policy was provided to the resident or responsible party at the time of transfer to the hospital.</p>	F 205	<p>Audits will be completed weekly for 4 weeks and then monthly. Audits will continue until substantial compliance is achieved as determined by QAPI.</p> <p>Audit results will be reviewed during QAPI meetings with revisions to the plan as deemed appropriate by the QAPI Committee.</p>		

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F 205	Continued From page 2 Medical record review revealed Resident #103 was admitted to the facility on 11/3/16 with diagnoses including Cerebral Infarction, Diabetes Mellitus with Diabetic Nephropathy, and Dementia. Medical record review revealed Resident #103 was transferred to the hospital on 11/16/16 for evaluation. Medical record review revealed no documentation a written bed-hold policy was provided to the resident or responsible party at the time of transfer to the hospital. Interview with the Assistant Director of Nursing on 1/31/17 at 9:02 AM, in the lobby, confirmed the residents were not provided a copy of the facility's bed-hold policy when the residents were transferred to the hospital. Interview with the Business Office Manager (BOM) on 1/31/17 at 9:40 AM, in the lobby, revealed the BOM was responsible to notify family members/responsible parties of the facility's bed-hold policy when residents were transferred to the hospital. Continued interview confirmed a written bed-hold notice was not provided to the family members or the resident's responsible party at the time the residents were discharged to the hospital.	F 205			
F 223 SS=G	483.12 FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 223			

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F 223	<p>Continued From page 3</p> <p>and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. This REQUIREMENT is not met as evidenced by:</p> <p>Based on facility policy review, medical record review, review of employee files, review of facility investigation, and interview, the facility failed to prevent abuse of 1 resident (#139) of 32 residents reviewed. Resident #139 felt humiliated and suffered psychological harm.</p> <p>The findings included:</p> <p>Review of the facility policies, "Preventing Resident Abuse" and "Reporting Abuse to Facility Management", revised on 11/28/16, revealed "...Our facility will not condone any form of resident abuse...verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents...Mental abuse is defined as, but is not limited to, humiliation, harassment..."</p> <p>Medical record review revealed Resident #139 was admitted to the facility on 4/4/16 with diagnoses including Acute on Chronic Respiratory Failure with Tracheostomy, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease.</p> <p>Review of the employee file for the Central Supply Clerk (CSC) revealed the employee was also a Certified Nursing Assistant (CNA). Review revealed on 11/2/16, "...Employee was angry while in the dining room serving residents lunch and was heard using inappropriate language and</p>	F 223	<p>E223</p> <p>Resident 139 was interviewed by Social Worker on 1/29/17. She remains at her baseline for facility milieu involvement, psychosocial and emotional well-being.</p> <p>Aide identified no longer works for facility as of 2/1/17.</p> <p>Other residents interviewed by social services on 2/2/17 to determine if they had been spoken to in a disrespectful way. No other reports of inappropriate conversation or unprofessional conduct were identified per interviews. Education of staff began on 2/1/17. Sr Regional Clinical Coordinator provided training to administrator and director of nursing on 2/1/17. The policy for preventing resident abuse was reviewed by the administrator on 2/1/17 and deemed to be appropriate. Administrator re-educated all leadership staff in relation to abuse prohibition including definitions, reporting requirements, and provision of measures to ensure safety and protection of the resident(s). This was completed by 2/3/17. Mandatory in-service education was scheduled for facility staff across all departments for abuse prohibition including definitions, reporting requirements, and provision of safety</p>	2/06/17	

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F 223	<p>Continued From page 4</p> <p>cussing in front of residents...behavior was very disruptive and distracting in the dining room while residents were eating..."</p> <p>Medical record review of the Minimum Data Set (MDS) dated 1/6/17 revealed the resident was cognitively intact with the highest possible score of 15 on the Brief Interview for Mental Status (BIMS).</p> <p>Review of a statement dated 1/29/17, obtained by the Director of Nursing (DON) from Resident #139, pertaining to an allegation of abuse on 1/27/17, revealed "...[CSC] jumped on her...was loud and rude...'made me feel humiliated'..."</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 1/30/17 at 3:45 PM, on the 600 hall, revealed on 1/27/17 Resident #139 "...came around the corner in her wheelchair crying." Continued interview revealed the CSC had yelled at her in the dining room related to the resident's oxygen, "...why do you need two [tanks of] oxygen..."</p> <p>Interview with LPN #1 on 1/30/17 at 5:10 PM, in the conference room, revealed "I spoke with [DON] before leaving my shift, about 2:15 PM, on Friday [1/27/17] to see what was being done about the incident in the dining room...talked over with [DON] that [Resident #139] was yelled at... [DON] said...she had started an investigation."</p> <p>Interview with Resident #139 on 1/30/17 at 6:00 PM, in her room, revealed the resident had been in the main dining room for lunch on Friday, 1/27/17, when she "...ran out of oxygen...have to have my oxygen...asked for my oxygen tank to be replaced, but [CSC] said she couldn't get it right away...3 times I asked her to get me a tank and</p>	F 223	<p>and protection of resident(s). Inservice records were audited against staff listings to ensure all staff received education. PRN staff and staff on leave will receive education prior to working.</p> <p>This education was provided with face-to-face opportunity for staff to ask questions and validate understanding of facility policies and regulatory requirements. This education was completed by 2/06/17.</p> <p>A Resident Council meeting was held by 2/6/17 to review abuse prohibition and discuss need for residents to immediately report inappropriate conversation or any action that might indicate a resident is being abused.</p> <p>To validate compliance, the staff development coordinator or social worker will interview five staff members and five residents weekly for four weeks. Non-interviewable residents will be observed by nurses during medication administration and routine nursing care for changes that may indicate abuse. If no issues are identified the facility will interview one staff member and one resident weekly for eight weeks to ensure unreported abuse has not occurred and that staff members can demonstrate knowledge and understanding of the</p>		

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F 223	<p>Continued From page 5</p> <p>she wouldn't, then [CNA #4] went out the door to get me a tank..." Interview continued as the resident began to cry. Further interview revealed "...she [CSC] yelled at me and told me I wasn't supposed to have 2 oxygen tanks...I was so upset...I couldn't sleep all night..."</p> <p>Interview with the Activities Assistant (AA) on 1/31/17 at 12:25 PM, in the conference room, revealed the AA was working on "bulletin boards" and observed Resident #139 "...as she came around the corner to the 600 Hall." Interview continued, "[Resident #139] came up to me crying on Friday [1/27/17] and explained to me what happened. I told her to report it immediately to [Staff Development Coordinator (RN #3)] and [Assistant Director of Nurses]. [Resident #139] said she ran out of oxygen and [CNA #4] went out the dining room door to go get her some...[CSC] asked 'Why do you need 2 oxygen [tanks]?' [Resident #139] comes to a lot of activities and she normally is not upset and I knew she was really upset that day [1/27/17]."</p> <p>Interview with CNA #4 on 1/31/17 at 12:35 PM, in the conference room, confirmed Resident #139 was in the dining room before lunch service on 1/27/17, and reported her oxygen tanks were empty. Continued interview confirmed the CSC was yelling at Resident #139, "...was very loud...sounded like a pissed off mother scolding her child...the lady [Resident #139] was crying and was tore up...everybody in there heard it...the lady [Resident #139] kept telling her she couldn't breathe...[CSC] yelled what are you doing with 8 liters of oxygen..."</p> <p>Interview with the Assistant Director of Nurses (ADON) on 1/31/17 at 2:17 PM, in the conference</p>	F 223	<p>policies and procedures of the facility. Interviews will continue until substantial compliance is achieved as determined by QAPI.</p> <p>AD HOC QAPI meeting was held on 1/30/17 to review facility plan of correction for concern identified which included Administrator, DON designee, Medical Director and 3 Department Leadership members.</p> <p>To validate compliance, results of staff and resident interviews will be reviewed during QAPI meetings with revisions to the plan as deemed appropriate by the QAPI Committee.</p>		

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F 223	Continued From page 6 room, revealed the ADON asked the Staff Development Coordinator (RN #3) what was going on after RN #3 had spoke to [CSC]. Continued Interview revealed the ADON, "...overheard [Resident #139] reporting to [the DON] and [RN #3] about being talked to in the manner [CSC] did...aware several disciplinary actions against [CSC]." Interview continued and the ADON confirmed she was aware the resident was upset and did not check on her. Interview with RN #3 on 1/31/17 at 2:28 PM, in the conference room, revealed RN #3 had been summoned by the AA to talk with Resident #139 and CNA #4 about the incident in the dining room on 1/27/17. Interview with RN #3 confirmed Resident #139 was visibly upset during the interview. Further interview revealed, "[CNA #4] said [CSC] has no right to talk to [Resident #139] like that." Further interview revealed RN #3 then told the DON, "[CSC] had mouthed somebody."	F 223			
F 225 SS=G	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;	F 225			

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F 225	<p>Continued From page 7</p> <p>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or</p> <p>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.</p> <p>(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.</p> <p>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>(2) Have evidence that all alleged violations are</p>	F 225	<p>F225</p> <p>Resident 139 was interviewed by Social Worker on 1/29/17. She remains at her baseline for facility milieu involvement, psychosocial and emotional well-being.</p> <p>Aide identified no longer works for the facility as of 2/1/17.</p> <p>Preliminary report of event reported to state agency on 1/30/17 with final report submitted to state agency 2/3/17 by the director of nursing.</p> <p>Current residents who can participate in interviews were interviewed by social services on 2/2/17 to determine if they had been spoken to in a disrespectful way.</p> <p>Staff were interviewed by staff development coordinator to determine if they had knowledge of disrespectful treatment/verbalizations in the presence of residents. These interviews were completed by 2/3/17.</p> <p>Facility reviewed records for any allegations of abuse for the past 30 days and none were identified.</p>	2/06/17	

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F 225	<p>Continued From page 8 thoroughly investigated.</p> <p>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on facility policy review, review of employee education materials, medical record review, review of a facility investigation, and interview, the facility failed to follow policy for investigating and reporting an allegation of abuse timely for 1 resident (#139) of 4 residents reviewed for abuse of 32 residents reviewed.</p> <p>The findings included:</p> <p>Review of the facility policy "Reporting Abuse to Facility Management" revised 11/28/16, revealed "...When an alleged or suspected case of...abuse is reported, the facility Administrator, DON [Director of Nursing], or individuals designated will immediately (not to exceed 24 hours...) notify the following persons or agencies of such incident as indicated by State or Federal Licensure Policy...the State licensing/certification agency responsible for surveying/licensing the facility...Verbal abuse is defined as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents...Mental abuse is defined as, but is not</p>	F 225	<p>The policy for reporting resident abuse was reviewed by the Administrator on 2/1/17 and deemed to be appropriate.</p> <p>Education began on 2/1/17. Sr Regional Clinical Coordinator provided training to administrator and director of nursing on 2/1/17. Administrator re-educated all leadership staff in relation to abuse prohibition and reporting abuse including definitions, reporting requirements, and provision of measures to ensure safety and protection of the resident(s). This was completed by 2/3/17.</p> <p>Mandatory in-service education was scheduled for facility staff across all departments for abuse prohibition and reporting abuse including definitions, reporting requirements, and provision of safety and protection of resident(s). PRN staff and staff on leave will receive education prior to working. This education was provided with face-to-face opportunity to ask questions and validate understanding of facility policies and regulatory requirements. This education was completed by 2/06/17.</p> <p>A Resident Council meeting was held by 2/6/17 to review abuse prohibition</p>		

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F 225	<p>Continued From page 9</p> <p>limited to, humiliation, harassment...Any individual observing an incident of resident abuse...must immediately report such incident to the Administrator or Director of Nursing...An immediate investigation will be made..."</p> <p>Review of an employee education document, "Reporting Abuse", undated, revealed, "...Provide for the Protection of the Resident...Suspend involved staff member pending investigation..."</p> <p>Medical record review revealed Resident #139 was admitted to the facility on 4/4/16 with diagnoses including Acute on Chronic Respiratory Failure with Tracheostomy, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease.</p> <p>Review of a facility investigation dated 1/29/17, documented by the Director of Nursing (DON), related to an allegation of abuse on 1/27/17 revealed "...[Resident #139] said [Central Supply Clerk (CSC)]...got upset with me & [and] questioned why I need 2 tanks [of oxygen] on my chair & I told her I can't breathe without it & it made me feel bad that she thought I didn't need 2 tanks & I was just wanting them. She also stated that [CSC] jumped on her & CNA [Certified Nursing Assistant #4] both & was loud & rude to them..."</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 1/30/17 at 3:45 PM, on the 600 hall, revealed on 1/27/17 Resident #139 came around the corner in her wheelchair crying. Interview continued and revealed LPN #1 was told the CSC had yelled at Resident #139 in the dining room related to her oxygen, "...why do you need two [tanks] of oxygen..." Interview continued, "I talked</p>	F 225	<p>and discuss need for residents to immediately report inappropriate conversation or any action that might indicate a resident is being abused.</p> <p>To validate compliance, the staff development coordinator and social worker will interview five staff members and five residents weekly for four weeks. Non-interviewable residents will be observed by nurses during medication administration and routine nursing care for changes that may indicate abuse. If no issues are identified the facility will interview one staff member and one resident weekly for eight weeks to ensure unreported abuse has not occurred and that staff members can demonstrate knowledge and understanding of the policies and procedures of the facility. Interviews will continue until substantial compliance is achieved as determined by QAPI.</p> <p>AD HOC QAPI meeting held to review facility plan of correction for concern identified which included Administrator, DON designee, Medical Director and 3 Department Leadership members. This meeting was held on 1/30/17. To validate compliance, results of staff and resident interviews will be reviewed during QAPI meetings with revisions to the plan as</p>		

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F 225	<p>Continued From page 10</p> <p>with [the Director of Nursing (DON)] by the end of my shift, probably by 2:15 PM."</p> <p>Interview with Resident #139 on 1/30/17 at 6:00 PM, in her room, revealed the resident was in the main dining room for lunch on Friday, 1/27/17, when she, "...ran out of oxygen...have to have my oxygen...asked for my oxygen tank to be replaced, but [CSC] said she couldn't get it right away...3 times I asked her to get me a tank and she wouldn't, then [CNA #4] went out the door to get me a tank..." Interview continued as the resident began to cry. Continued interview revealed "...she [CSC] yelled at me and told me I wasn't supposed to have 2 oxygen tanks...I was so upset...I couldn't sleep all night..." Further interview revealed the resident had reported the incident to the DON on 1/27/17.</p> <p>Interview with CNA #4 on 1/31/17 at 12:35 PM, in the conference room, confirmed Resident #139 was in the dining room before lunch service on 1/27/17 and reported her oxygen tanks were empty. Continued interview confirmed CNA #4 went through the dining room exterior door to retrieve full oxygen tanks. Continued interview confirmed the CSC was yelling at Resident #139 and "...was very loud...sounded like a pissed off mother scolding her child...the lady [Resident #139] was crying and was tore up...everybody in there heard it...the lady [Resident #139] kept telling her she couldn't breathe...[CSC] yelled what are you doing with 8 liters of oxygen..."</p> <p>Interview with the DON on 1/31/17 at 4:23 PM, in the conference room, revealed facility employees had witnessed the verbal abuse on 1/27/17 during lunchtime, the investigation of the verbal abuse was not initiated until 1/29/17, and the accused</p>	F 225			

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F 225	Continued From page 11 employee was allowed to finish working on 1/27/17 until 4:22 PM. Continued interview confirmed the CSC was suspended on her next scheduled workday [1/30/17 at 7:30 AM]. Continued interview revealed the facility failed to follow their policy and the verbal abuse was not reported to the State agency until 1/30/17.	F 225	deemed appropriate by the QAPI Committee.	2/09/17	
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, interview, and observation, the facility failed to prevent development of a stage 2 pressure ulcer for 1 resident (#40), of 3 residents reviewed with medical devices, of 32 residents reviewed. The findings included:	F 314	F314 Resident 40 had her wound re- evaluated and re-classified by the wound nurse/RN on 2/1/17. Physician was notified and orders obtained on 1/27/17. Resident responsible party was notified. Current residents with medical devices had their skin evaluated by nurses by 2/3/17. No other areas identified. Facility documents cited in the 2567 were reviewed by the DON by 1/31/17 and deemed to be appropriate. Facility nurses were re-educated by the SDC starting on 2/6/17 and this was completed by 2/09/17 regarding prevention of pressure ulcers from medical devices. PRN staff and staff on leave will receive education prior to working. Audits will be completed to validate that residents who utilize medical devices have weekly skin assessments completed by nurses and that any wounds are classified based on their characteristics. Administrative nurses will complete these audits weekly for 4 weeks and then monthly.		

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F 314	<p>Continued From page 12</p> <p>Review of the facility policy "Prevention of Pressure Ulcers", revealed, "...The most common site of a pressure ulcer is where the bone is near the surface of the body...Pressure can also come from splints, cast..."</p> <p>Review of the facility's "Clinical Practice Guideline...International NPUAP/EPUAP Pressure Ulcer Classification System" revealed, "...Stage II: Partial Thickness Skin Loss...Partial thickness loss of dermis presenting as a shallow open ulcer..."</p> <p>Resident #40 was admitted to the facility on 12/15/16 with diagnoses including Urinary Tract Infection, Dementia, Atrial Fibrillation, and Osteoporosis with Compression Fractures of the Lumbar Spine, and Vertebral Augmentation Surgery on 12/14/16.</p> <p>Medical record review of the nursing assessment dated 12/15/16 revealed the resident did not have a pressure ulcer on admission. Further review revealed a Norton Plus Pressure Ulcer Scale used for predicting pressure ulcer risk was scored at a "9", with the instruction "score 10 or less = high risk."</p> <p>Medical record review of the care plan dated 12/23/16 revealed the "Focus" problem, "Risk for alteration in skin integrity".</p> <p>Medical record review of a "Continuity of Care" record dated 12/30/16, revealed the Medical Director wrote "...Back brace when ambulating...Needs to get up to go to the bathroom, wear Back brace when ambulating."</p> <p>Medical record review of a physician's telephone</p>	F 314	<p>Audits will continue until substantial compliance is achieved as determined by QAPI. They will be reviewed during QAPI meetings with revision to the plan as deemed appropriate by the QAPI Committee.</p>		

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F 314	<p>Continued From page 13</p> <p>order dated 12/30/16 revealed, "Back brace when up in w/c [wheelchair] as tolerated..."</p> <p>Medical record review of the December 2016 Treatment Record revealed, "Back brace when up in the w/c [wheelchair] as tol [tolerated.]"</p> <p>Medical record review of the physician's telephone orders dated 1/2/17 revealed, "Order Clarification: Back brace on when ambulating."</p> <p>Medical record review of the Minimum Data Set (MDS) dated 1/12/17, revealed the resident had scored a 12 on the Brief Interview for Mental Status (BIMS) indicating mild cognitive impairment, and the resident required assist of 1 person for transfers and ambulation.</p> <p>Medical record review of the resident's weekly skin check dated 1/27/17 revealed no open areas were identified.</p> <p>Medical record review of an "Immediate Plan of Care" dated 1/27/17 revealed, "Problem...abrasion..."</p> <p>Interview with Registered Nurse (RN) #1 on 1/30/17 at 9:40 AM, at the nursing station, revealed, "...[Resident #40] has an open area on her back from rubbing against a brace." Interview revealed RN #1 "thought the wound care nurse classified it as an abrasion..."</p> <p>Interview with the Wound Care Nurse, RN #2, on 1/30/17 at 2:00 PM, revealed RN #2 had not observed the resident's "abrasion" since first observed on the previous Friday, 1/27/17.</p> <p>Observation of Resident #40 on 1/30/17 at 2:30</p>	F 314			

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F 314	<p>Continued From page 14</p> <p>PM, with RN #2, revealed the resident was able to turn off of her back to the right side of the bed, and there was a prominent curve of the resident's spinal column. There was an open area that was not covered with a dressing and was located on the most protruding bony prominence of the curvature of the spine. The open area was circular and measured 1.5 cm (centimeters) by 1.5 cm, with a red rim visualized at the bottom portion of the open area. There was a periwound, red in color, and measuring 4 cm by 4 cm.</p> <p>Interview with RN #2 on 1/30/17, at 2:30 PM, during the observation in the resident's room, confirmed the size of the open area and the periwound area. Further interview revealed the RN continued to state the open area was an "abrasion."</p> <p>Interview with the Assistant Director of Nursing (ADON) on 1/30/17, at 3:30 PM, in the conference room, confirmed the ADON supervised the facility's wound care program, and confirmed an open area on a bony prominence was a stage II pressure ulcer.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 1/31/17 at 9:50 AM, in the conference room, revealed the Certified Nursing Assistants (CNA's) bathing Resident #40 on 1/27/17 reported the open area on the resident's back. Interview confirmed the physician's order written on 12/30/16 to apply the brace when the resident was "in the w/c" was not the order written by the physician on the "Continuity of Care" instructions. Further interview revealed, "I noticed when she was sitting in the w/c the top of the brace came right to the bony spot on her back..."</p>	F 314			

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F 314	Continued From page 15	F 314	F441	2/09/17	
F 441 SS=D	<p>Interview with the ADON on 1/31/17 at 4:00 PM, in the 300 Hall, confirmed Resident #40 had developed a stage II pressure ulcer on the bony curvature of her spine where the back brace came into contact with the curvature of her spine, and confirmed the physician had not ordered the brace to be worn in the wheelchair.</p> <p>483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be</p>	F 441	<p>The 6 residents have received assistance with meals with appropriate hand hygiene. This was observed by management staff on 1/30/17.</p> <p>Current residents were observed by nurses by 2/3/17 to validate appropriate hand hygiene was completed while assisting residents with meals.</p> <p>The hand hygiene policy was reviewed by the director of nursing on 1/29/17 and deemed appropriate. Mandatory in-service education began on 2/06/17 for facility staff regarding hand hygiene. This education was completed by 2/09/17. PRN staff and staff on leave will receive education prior to working.</p> <p>Audits will be completed by nurses beginning on 1/30/17 to validate that hand hygiene is completed while assisting residents with meals. The audits will be completed weekly for 4 weeks and then monthly. Audits will continue until substantial compliance is achieved as deemed by QAPI committee.</p> <p>Audit results will be reviewed during QAPI meetings with revision to the 2/09/17 plan as deemed appropriate by the QAPI Committee.</p>		

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F 441	<p>Continued From page 16 reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on review of the facility policy, observation, and interview, the facility failed to</p>	F 441			

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F 441	<p>Continued From page 17</p> <p>perform hand hygiene between residents for 6 of 24 residents observed in the dining room during the lunch meal service.</p> <p>The findings included:</p> <p>Review of the facility policy, Hand Hygiene, not dated, revealed "...require hand hygiene...Before and after direct resident contact...Before and after assisting a resident with meals (hand washing with soap and water) ..."</p> <p>Observation of Certified Nursing Assistant (CNA) #3 on 1/29/17 at 11:10 AM, during lunch meal service in the dining room, revealed CNA #3 delivered lunch to the 1st resident, touched the eating utensils and removed a lid from her drink, while preparing the meal for consumption. Continued observation revealed CNA #3 moved a wheelchair, using both hands, and then served the 2nd resident their lunch, without sanitizing the hands. Continued observation revealed CNA #3 unwrapped the resident's eating utensils and used the utensils to cut the resident's food, then removed the lid from the resident's cup. Continued observation revealed CNA #3 assisted the 3rd resident to cut up their food. Continued observation revealed CNA #3 sanitized her hands, touched the doorknob on the dining room door, and delivered the 4th resident their meal. Continued observation revealed CNA #3 unwrapped the utensils and poured milk into the resident's cup, without sanitizing the hands. Continued observation revealed CNA #3 served the 5th resident their lunch tray, unwrapped the utensils, and used them to cut up the resident's food, without sanitizing the hands. Further observation revealed CNA #3 assisted the 6th resident to unwrap her utensils, and poured her</p>	F 441			

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F 441	<p>Continued From page 18</p> <p>drink into a glass without sanitizing the hands.</p> <p>Interview with CNA #3 on 1/29/17 at 11:23 AM, in the dining room, confirmed CNA #3 had not sanitized her hands between touching contaminated surfaces and delivering and assisting residents with meal set-up.</p> <p>Interview with the Director of Nursing on 1/29/17 at 11:45 AM, in the DON office, confirmed acceptable infection control practice was not performed and the facility's Hand Hygiene Policy was not followed.</p>	F 441			